SUMMARY DESCRIPTION

of the

CITY OF MINNEAPOLIS

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

January 1, 2015

SUMMARY PLAN DESCRIPTION

This summary is intended to explain the Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please call the City of Minneapolis Benefits Office at (612) 673-3333.

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I. THE PURPOSE OF THE PLAN

The City has adopted a medical plan coupled with a Healthcare Reimbursement Arrangement (HRA) and has established a Voluntary Employees' Beneficiary Association Trust (VEBA Trust) to fund Benefits under this Plan. The Plan consists of two component plans: the Health Reimbursement Arrangement – Active Plan ("HRA – Active Plan") and the Health Reimbursement Arrangement – Retiree Plan ("HRA – Retiree Plan"). The provisions of this Summary Plan Description apply to both the HRA – Active Plan and the HRA – Retiree Plan unless specifically stated to the contrary. Plan Benefits are available to reimburse Members for Eligible Health Expenses.

This description is not meant to interpret, extend, or change the provisions of this Plan in any way.

The provisions of this Plan may only be accurately determined by reading the actual Plan document. To obtain a copy of the Plan document you should contact the City of Minneapolis Benefits Office at 612-673-3333. **In the event of any discrepancy between this description and the actual provisions of the Plan, the Plan provisions will govern.**

II. DEFINITIONS

Following are definitions that will help you better understand this summary of this Plan:

Abandoned means that the Plan has not been able to make contact with the member for a 36 month period at the members last known address.

Account Balance means the amount in the Member Account.

Benefits means any amounts paid to a Member as reimbursement for Eligible Health Expenses incurred by the Member or the Member's Eligible Dependents.

Child means the Employee's biological child, step child, adopted child (including a child placed for adoption) and foster child provided such child as of the end of the applicable calendar year has not attained the age of 27.

Claims Administrator means the individual or entity retained by the City from time to time to administer all or a portion of this Plan.

Code means the Internal Revenue Code of 1986, as amended from time to time.

Contributions means Employer amounts deposited in the VEBA Trust pursuant to the terms of the Plan.

Eligible Dependent means the Employee's Spouse, the Employee's Child and any other person who qualifies is a dependent of the Employee for purposes of Sections 105 and 106 of the Code, as clarified in Revenue Procedure 2008-48.

Eligible Employee means any Employee who is eligible for and has elected coverage under the City of Minneapolis Medical Plan.

Eligible Health Expense means those expenses incurred by a Member or a Member's Eligible Dependent that are not covered by other insurance available to the Member and the Member's Eligible Dependents and are reimbursable expenses as defined by Code Section 213(d). Also included as eligible health expenses are transportation expenses for and essential to medical care, insulin, over-the-counter medicines or drugs provided the over-the-counter medicines or drugs are prescribed (determined without regard to whether such medicines or drugs are available without prescription) and medical equipment and supplies meeting the definition of medical care in Code Section 213(d)(1). For this purpose, an expense is "incurred" at the time the medical care or service which gave rise to the expense is furnished. For members of the HRA – Retiree Plan, Eligible health expenses also include the out-of-pocket portion of Medicare premiums, COBRA premiums and any other health insurance contract or plan premium incurred after the date of retirement from City employment.

Employee means any person hired and paid under the salary authority of the City Council or Independent Boards or Agencies who adopted this Plan, including any such person covered by a collective bargaining unit agreement providing for participation in this Plan, but does not include an independent contractor, a leased employee within the meaning of Code section 414(n), or a person hired by the City Council or an Independent Board or Agency under a personal services contract.

Employer means the City of Minneapolis, or any of the City's Independent Boards or Agencies that have adopted and not terminated this Plan. (A list of participating Independent Boards and Agencies is on file with the Benefits Office.)

Former Employee means an Employee who has severed employment with the Employer.

Health Reimbursement Arrangement-Active Plan or **HRA-Active Plan** means the component of the Plan in which Members who are Eligible Employees, non-Active Employees and non-Retiree Former Employees have Member Accounts.

Health Reimbursement Arrangement-Retiree Plan or **HRA-Retiree Plan** means the component of the Plan in which Members who are Retirees have Member Accounts.

Medical Expense Account means the component of the City of Minneapolis Minneflex Plan through which an Employee and the Employee's Eligible Dependents may have health care expenses reimbursed with pre-tax dollars.

Member means a current Employee or a Former Employee for whom Employer deposits have been received by the Trust and whose Member Account has a positive balance.

Member Account refers to the bookkeeping account maintained by this Plan's Claims Administrator in the name of an Employee which reflects all contributions made to the Trust in the name of the Employee, investment earnings and losses, administrative expenses, and distributions made for the payment of Eligible Health Expenses.

Non-Active Employee means an employee on a leave of absence during which Contributions to the plan are suspended. A Non-Active Employee is also an employee not currently enrolled in the City of Minneapolis Medical Plan with a member account balance.

Plan means the City of Minneapolis Healthcare Reimbursement Arrangement Plan, as it may be amended from time to time. Plan includes the two component plans: the HRA – Active Plan and the HRA – Retiree Plan unless specifically stated to the contrary.

Plan Year is the twelve month period ending each year on the last day of December.

Retiree means a Former Employee entitled to immediate commencement of benefits upon Severance under any public employees retirement act.

Severance means a Member's voluntary or involuntary termination of employment with the Employer.

Spouse means an individual who is legally married to an Employee (and who is treated as a spouse under the Code), but shall not include an individual separated from the Employee under a legal separation decree.

III. ELIGIBLITY AND PARTICIPATION

This Plan is maintained pursuant to collective bargaining agreements and Employer personnel policies and directives. Copies of the collective bargaining agreements are available from the City of Minneapolis Human Resources Department.

To participate in the Plan and receive Benefits under the Plan, you must:

1. Enroll in the City of Minneapolis Medical Plan;
2. Observe all Plan rules and regulations;
3. Agree to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan; and
4. Submit to the Claims Administrator all reports, bills, and other information that the Claims Administrator may reasonably require.

IV. PLAN BENEFITS

The City of Minneapolis has established this Plan to provide tax-free accounts for Members to pay for medical, dental, vision and tax qualified long-term care expenses that are not paid by other insurance plan(s).

This Plan is funded by Employer Contributions that are credited to your Member Account. Member contributions are not permitted. Contribution amounts may vary based on the medical plan option you elect, whether you choose single or family medical coverage and whether or not you participate in certain Employer sponsored wellness initiatives. You can use this Plan to be reimbursed for Eligible Health Expenses that are incurred by you and your Eligible Dependents on or after the date you enroll in the City of Minneapolis Medical Plan.

Benefits are available to Retirees for the out-of- pocket portion of Medicare premiums, COBRA premiums or any other health insurance contract or plan. Benefits for such expenses are not available to Employees, Non-Active Employees or Former Employees.

Benefits are **not** available to reimburse expenses that are reimbursable by your Medical Expense Account until after the Medical Expense Account has paid expenses totaling the dollar amount of your Medical Expense Account election.

V. BENEFIT REIMBURSEMENT RULES

1. What Expenses Can be Reimbursed under the Plan?

The Plan will only reimburse Eligible Health Expenses that are incurred on or after the date you enroll in the City of Minneapolis Medical Plan. All claims must be submitted for reimbursement no later than 18 months after the end of the plan year in which the expense was incurred.

Example: You enroll for medical coverage effective January 1st and you automatically become a Plan Member on that date. You can receive reimbursement only for eligible expenses incurred on or after the date you are first enrolled in the City of Minneapolis Medical Plan.

Eligible Health Expenses are expenses incurred by you or an Eligible Dependent that are:

- not covered by other insurance available to you or to an Eligible Dependent; and
- are reimbursable expenses as defined by Code Section 213(d).

Examples of Eligible Health Expenses are medical, prescription drug, dental, vision and qualified long-term care expenses including the deductibles, co-payments, and co-insurance you pay under the City-sponsored medical and dental plans. For Retirees only, Eligible Health Expenses include the out-of-pocket portion of Medicare premiums, COBRA premiums and any other health insurance contract or plan premium incurred after the date of retirement from City employment.

Under no circumstance will an expense be reimbursed under this Plan if the expense is provided, paid by any other health or accident plan or insurance policy covering you or an Eligible Dependent (including Social Security, Medicare or Medicaid) or if you will be reimbursed for the expense from another source.

Benefits are **not** available to reimburse expenses that are reimbursable by the Medical Expense Account until after the Medical Expense Account has paid expenses totaling the dollar amount you elected to contribute to the Medical Expense Account for the Plan Year.

Benefits will always be limited to a your actual Account Balance. If claims are mistakenly paid that exceed your Account Balance, you will be responsible for reimbursing the Plan for such excess amount. To recover excess payments, the Plan may reduce future reimbursement payments to or on your behalf. The right to offset future benefit payments does not limit this Plan's right to recover overpayments in any other manner.

2. When is an Expense "Incurred"?

A health care expense is incurred at the time the medical care or service which gave rise to the expense is furnished. The date of billing or payment is irrelevant.

Example: Jones visits his doctor on March 15th and is billed for the services subject to the deductible on April 5th. Jones pays the bill on April 14th. Jones incurred the expense when he visited his doctor on March 15th.

3. Who is an Eligible Dependent under the Plan?

An Eligible Dependent is your Spouse , your Child or "qualifying relative" under Section 152 of the Code. In general, a person will qualify as an Eligible Dependent for a Plan Year if the person lives with you for more than one-half (1/2) of the year and you provide more than one-half (1/2) of his or her support during the Plan Year and certain other tests are met.

Your Child includes your biological child, step child, adopted child (including a child placed for adoption) and foster child provided such child is under the age of 27 as of the end of the tax year.

"Qualifying relatives" will usually include other individuals who:

- are either related to you by blood or marriage and live in your home as a member of your household during the entire Plan Year; and
- receive more than one-half (1/2) of his or her support from you; and
- are not the dependent child of any other taxpayer.

A temporary absence from your home will not disqualify an individual from being an Eligible Dependent unless there is reason to believe the individual will not return to your home. *Example:* If a student lives in a condo purchased by his or her parents, it is not reasonable to believe the student will return to the parents' home. Therefore, the student is not an Eligible Dependent.

The instructions on your federal income tax return discuss in some detail who qualifies as your Eligible Dependent.

4. How Do I Claim Plan Benefits?

There are three options to claim Plan Benefits:

- Pay Me Back
- Pay My Provider
- Health Care Card

Pay Me Back

In this option, you pay for the expense with your own funds and then request reimbursement from the Claims Administrator. Pay Me Back claims must either be submitted in paper by delivering a completed claim form to WageWorks, the current Claims Administrator, or submitted electronically by visiting their website at www.wageworks.com. A paper claim form may be obtained from the City of Minneapolis Benefits Office by calling 612-673-3333 or from WageWorks by calling 855-428-0446.

The Pay Me Back claim form, electronic or paper, includes information such as:

- the name of the person on whose behalf Eligible Health Expenses have been incurred;
- the nature of the expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source. Other information regarding the claim may be reasonably requested by the Claims Administrator.

You must include a copy of your bill or receipt or other documentation of the type and amount of the expense and the date(s) the expense was incurred (a canceled check is not sufficient).

After your claim is reviewed, processed, and approved, you will receive a reimbursement. Claims with missing or illegible information will be denied, pending re-submission of legible information.

Pay My Provider

Pay My Provider is an option you can use to have payment sent directly to your provider from your online WageWorks account. Pay My Provider claims can only be submitted online via your online account at www.wageworks.com. Refer to your provider invoice or contact your provider to find out what check information is needed for your provider to process the payment. All information is verified when the claim is processed.

Through your online WageWorks account, you can also arrange for WageWorks to make recurring monthly payments to your provider. To do so, you will need a contract from your provider that includes:

- the provider name,
- patient name,
- description of service,
- payment schedule including dates of service and payment amount.

WageWorks Health Care Card

The WageWorks Health Care Card may be used only for only for eligible expenses incurred in the current year by HRA- Active Plan Members. Use your WageWorks Health Care Card to pay for eligible products and services. You will need to keep your receipts as the IRS requires that all card transactions be verified as paying for eligible expenses. To do this, WageWorks may need to request you to submit a detailed receipt or other documentation that shows what purchase or service was paid using the Health Care Card. This request will appear on your online account or through the e-mail address you have set up with your WageWorks online account.

5. How Often are Claims for Reimbursement Paid?

Benefits are paid at least semi-monthly.

6. How are Reimbursements from the Plan Coordinated with Reimbursements from my Medical Expense Account?

If you elected to participate in the Minneflex Medical Expense Account, submitted health expenses will be applied to the Medical Expense Account first until that account is exhausted. Additional claims may then be applied to your Member Account in this Plan. Claims for reimbursement that exceed the balance remaining in your Medical Expense Account will not automatically be paid by this Plan.

First you must contact WageWorks by phone or online and instruct them to change your account settings to “Spend It”.

Example: Your remaining Medical Expense Account balance is $100 and you submit a claim for Eligible Health Expenses totaling $150. $100 will be reimbursed from your Medical Expense Account, but the remaining $50 will not be paidfrom your Member Account until your account settings have been changed to "Spend It".

7. How Long Do I Have to Submit a Claim for Reimbursement?

All claims must be submitted for reimbursement no later than 18 months after the end of the plan year in which the expense was incurred.

Claims may not be submitted for expenses incurred after the date an individual ceases to be an eligible dependent.

8. How Long May I Continue to Participate in the Plan?

If you leave employment or cease to participate in the City of Minneapolis Medical Plan, your Account Balance will be available to you for reimbursement of Eligible Health Expenses. If the plan has been unable to contact you for 36-month period at your last known address, your remaining Account Balance will be forfeited and will be used to pay future administrative expenses.

9. Are Survivor Benefits Provided under the Plan?

If you die with an Account Balance, your Member Account will transfer to your Spouse. If you have no Spouse, your Eligible Dependents are entitled to the reimbursement of Eligible Health Expenses they incurred as of and following your date of death. Eligible Health Expenses incurred in the 18 months prior to death can also be reimbursed by the Plan.

10. Could my Member Account Balance Ever Be Forfeited?

A Member's Account balance is forfeited on the earlier of:

a. The date on which the Member Account is determined to be Abandoned; or
b. If continued participation in lieu of COBRA is elected, the date on which:
   (i) The Member dies without a surviving Eligible Dependent; or
   (ii) The Member's longest surviving Eligible Dependent dies.
c. If continuation coverage is elected under COBRA, the date on which: (i) The COBRA continuation period ends; or
   (ii) The required COBRA contributions are not received when due.

11. What Happens to Forfeited Amounts?

Amounts that are forfeited under circumstances outlined 10 above are used to pay future administrative expenses. In no case may these forfeitures revert to the Employer.

VI. RESTRICTIONS ON RECEIVING BENEFITS

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before Benefits under the Plan will be nontaxable to all employees. If the Employer believes that any of these requirements or limits may be violated, it may limit the amount of Benefits available to certain members so that this Plan and its Benefits remain nontaxable.

VII. LEAVES OF ABSENCES INCLUDING FAMILY OR MEDICAL LEAVES

If you take a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), your participation in this Plan will continue in the same manner as your participation in the City of Minneapolis Medical Plan.

If you take a leave of absence under FMLA, you should contact the benefits office to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid FMLA leave, you may continue to participate in the Plan.

Please contact the City of Minneapolis Benefits Office at (612) 673-3333 as soon as you know you will be taking a leave of absence.

IX. HOW BENEFITS ARE TAXED

Subject to applicable requirements discussed in question VI above, the Code provides that Employer Contributions and any earnings used to pay for Benefits will not be subject to federal or state income taxes or to social security taxes. Benefit payments will not be reduced by income tax or social security withholding.

X. PLAN EXPENSES

Employee Member Accounts are not currently charged for trustee fees, claims administration fees or Plan administration expenses. Beginning the January 1st of the Plan Year following the year in which Former Employee or Retiree experiences a one year break in service, the Former Employee or Retiree will pay $1.50 per month for claims administration and Plan administration expenses. Such fees are deducted from the Former Employee's or Retiree's Member Account. Other necessary Plan expenses, as well as consultant and investment manager expenses are currently paid by the Employer, although such fees and expenses may instead be charged to Member Accounts.

XI. TERMINATION OF EMPLOYMENT

In the event of your Severance, Contributions will cease. Your Account Balance will be available to you for reimbursement of Eligible Health Expenses. Subject to rights you may have to continue coverage, you may be able to elect to continue to make after-tax contributions. (See RIGHTS TO CONTINUATION COVERAGE.) If you stop making payments toward that coverage, the coverage will cease.

XII. AMENDING OR TERMINATING THE PLAN

The City reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended, your benefits accrued prior to the amendment will not be affected. Benefits for periods after the amendment will depend on the nature of the amendment. If the Plan is terminated, you will not lose your Member Account balance.

XIII. RIGHTS TO CONTINUATION COVERAGE

Under a federal law that is commonly known as COBRA and Minnesota State law, employers sponsoring "group health plans" are required to offer the opportunity for a temporary extension of health coverage (called "continuation coverage") in certain instances where coverage under the plan would otherwise end. This Plan qualifies as "group health coverage" for purposes of COBRA and Minnesota state law. The following paragraphs are intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law as it applies to the HRA – Active Plan. To request a copy of the City of Minneapolis Health Reimbursement Arrangement Plan COBRA Policy and Procedure[s], please contact the City of Minneapolis Benefits Office at (612) 673-3333.

You have a right to choose this continuation coverage if you lose your group health coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

When the Employer is notified that one of these events has happened, the Employer, in turn, will notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Employer that you want continuation coverage.

Under the law, the employee or a family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under a COBRA plan. Notice must be given to the Employer within 60 days of the happening of the event.

If you do not choose continuation coverage, your group health coverage will end as of the end of the month in which you paid your last premium.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. The law requires that you are eligible to continue coverage for no more than 18 months after termination of employment or 36 months after any other qualifying event. For an employee or family member who is disabled at the time of the employee's termination or reduction in hours or who becomes disabled during the first 60 days of COBRA coverage, the continuation coverage period is 29 months. The disability that extends the continuation coverage period must be determined by the Social Security Administration under Title II (Old Age, Survivors, and

Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. Such determination must be made within the first 18 months of COBRA continuation coverage. For the 29-month continuation coverage period to apply, the covered employee or other qualified beneficiary must notify the Employer within 60 days of the determination of disability under the Social Security Act and within the first 18 months of COBRA continuation coverage.

The Employer may charge 102% of the appropriate premium not otherwise subject to the disability extension.

If a second qualifying event occurs within 18 months after a termination or reduction in hours, you have three years of continuing coverage from the date of the original qualifying event. If you or a family member have a 29-month continuation period by reason of a disability, as described above, and another qualifying event (other than bankruptcy) occurs within the 29-month continuation period, then the continuation coverage period is 36 months from the termination of employment or reduction in hours.

The law provides that your continuation coverage may be cut short for any of the following reasons:

1) The Employer no longer provides group health coverage to any of its employees;
2) The premium for coverage is not paid on time;
3) The normal time period for which continuation coverage must be allowed expires.

If you have any questions about the law, please contact the City of Minneapolis Benefits Office at (612) 673-3333. Also, if you change your marital status, or you change your address, please notify the City's Benefits Office.

If you take a military leave of absence, you may have a right to have your coverage continued under the Plan.

XIV. CLAIM FOR BENEFITS

In the event the Claims Administrator determines that a Request for Benefits is questionable, the Claims Administrator shall, within fifteen (15) days from the date the Claimant's (for purposes of this section, a Claimant is defined as a person claiming benefits under this Plan) request for Plan Benefits was received by the Claims Administrator, unless special circumstances require an extension of time for reviewingsaid Request for Benefits, provide the Claimant with written notice of its need for additional information. In the event special circumstances require an extension of time for reviewing the Claimant's Request for Benefits, the Claims Administrator shall, prior to the expiration of the initial fifteen (15) day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Claims Administrator expects to render its decision. In no event shall such extension exceed a period of sixty (60) days from the date of the expiration of the initial period.

If the Claimant's Request for Benefits is denied, in whole or in part, by the Claims Administrator, the Claims Administrator shall notify the Claimant of such denial and shall include in such notice, set forth in a manner calculated to be understood by the Claimant, the following:

- The specific reason or reasons for the denial; and
- Specific reference to pertinent Plan provisions or IRS rules on which the denial is based; and A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the Claimant wishes to submit his/her claim for review.

In the event written notice of a denial of a Request for Benefits is not provided to the Claimant in the manner set forth in this section, the request shall be deemed denied as of the date on which the Claims Administrator's time period for rendering its decision expires.

A Claimant may appeal the denial of the Request for Benefits by submitting a written Request for Review of Denial of Benefits no later than sixty (60) days from the date the Claimant received written notification of the Claim's Administrator's initial denial of the claimant's Request for Benefits or from the date the Request for Benefits was deemed denied, unless the Claims Administrator, upon the written application of the Claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

The written Request for Review of Denial of Benefits may request either a hearing or a written reconsideration. If a hearing is requested, the Claimant and any person the Claimant chooses may present testimony or other information. The Claimant is entitled to examine all pertinent documents and to submit issues and comments in writing.

The Claims Administrator will provide the Claimant written notice of its determination and all key findings within 45 days after the Claims Administrator receives the Claimant's written request for a hearing. If a Claimant requests a written reconsideration, the Claimant may provide the Claims Administrator with any additional information the Claimant believes is necessary. The Claims Administrator will provide the Claimant written notice of its determination and all key findings within 30 days after the Claims Administrator receives the Claimant's request for a written reconsideration. The Claims Administrator decision on Request for Review of Denial of Benefits shall be furnished to the Claimant and shall:

- Be written in a manner calculated to be understood by the Claimant; Include specific reasons for its decision; and
- Include specific references to the pertinent Plan provisions or IRS rules on which the decision is based.

If the Claims Administrator is unable to make a determination within the time prescribed by this section due to circumstances outside its control, the Claims Administrator may take up to 14 additional days to make a determination. If the Claims Administrator takes more time than prescribed to make a determination, the Claims Administrator will inform the Claimant in advance of the reason for the extension.

The claims procedures set forth above shall be strictly adhered to by each Claimant under this Plan, and no judicial or arbitration proceedings with respect to any claim for Plan

Benefits hereunder shall be commenced by any such Claimant until the proceedings set forth herein have been exhausted in full.

You (or your counsel) also have the right to review the pertinent documents. If you do not request a hearing, within the appropriate period after the Claims Administrator receives your petition, the Claims Administrator shall notify you, in writing, of its decision, stating specifically the basis of said decision and the provisions of the Plan on which the decision is based. The Claims Procedure is set forth in full in the Plan.

XV. HIPAA PRIVACY

Regulations issued under the federal Health Insurance Portability and Accountability Act (HIPAA) protect the privacy of your health information under this Plan. These regulations are generally referred to as the HIPAA Privacy Rules. Generally, these rules require this Plan to take sufficient steps to protect any medical information that might identify you individually from other sources and to allow you to have access to this information. A Notice of Privacy Practices was sent to you at the time you became eligible to participate in this Plan. This notice describes in detail how the HIPAA Privacy Rules affect you and the Employer. The notice also describes five individual rights which apply to you under the privacy rules:

- The right to inspect and copy your protected health information
- The right to request restrictions
- The right to request confidential communications
- The right to amend your protected health information
- The right to receive an accounting of certain disclosures of your protected health information

To request a copy of the Notice of Privacy Practices, please call the City of Minneapolis Benefits Office at (612) 673-3333.

XVI. GENERAL ADMINISTRATIVE INFORMATION

Name of the Plan:	City of Minneapolis Health Reimbursement Arrangement Plan
Plan Sponsor and Plan Administrator:	City of Minneapolis Room 100, 250 South Fourth Street Minneapolis, MN 55415-1335 (612) 673-3333
Plan Sponsor Identification Number:	41-6005375
Claims Administrator:	WageWorks 3101 Sessions Rd Tallahassee, FL 32303 (800) 872-0345
Plan Number:	515
Plan Year:	January 1 – December 31
Type of Plan:	This Plan is commonly known as a Health Reimbursement Arrangement Plan. It consists of two component plans: the Health Reimbursement Arrangement – Active Plan ("HRA – Active Plan") and the Health Reimbursement Arrangement – Retiree Plan ("HRA – Retiree Plan"). It is an employer-funded plan that provides for the tax free reimbursement of health care expenses which eligible employees might otherwise be required to pay on an after-tax basis. It is classified as an "accident or health plan" under Code Section 105.
Type of Funding:	The HRA – Active Plan is funded through a Voluntary Employees' Beneficiary Association (VEBA) Trust established by the City of Minneapolis and to which the Employer contributes.
Trustee:	U.S. Bank, N.A.
Type of Administration:	The City of Minneapolis has overall responsibility for the administration of this Plan. However, certain administrative services are provided by WageWorks under a contract with the City.
Agent for Service of Legal Process:	City of Minneapolis City Clerk 350 South 5th Street. Room 304 Minneapolis, MN 55415-1316 Legal process may also be served on the Trustee or the Plan Administrator.
Requests for Information:	If you have any questions regarding your benefits, please contact City of Minneapolis Benefits Office at (612) 673-3333.

Requests for Review of Denial of Benefits should be in writing and should be hand delivered or sent by certified mail to the Claims Administrator.